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Genitality Reached by a Chronic Depressive

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Dr. L is a 36-year-old, white Jewish internist, whom I first saw in January of 1974. He appeared unexpectedly on my doorstep with his wife about one week in advance of his first scheduled appointment. A glance at his face revealed a crisis situation, so I quickly ushered him in for an emergency session.

Dr. L was tremulous, agitated, and acutely anxious. The anxiety was triggered by a vibrant, young cousin of his, a "hippie type" according to the patient, who had been visiting for several days and stirring up a good deal of "fun and excitement" for his wife, M. The patient felt as if his domicile had been invaded; he felt great anger toward his cousin, which he restrained; most of all he experienced a deep sense of inadequacy because "I couldn't do that for M." Although he keenly wished the cousin to leave, he bade him stay on, preferring to take the pain upon himself since "I am the one who's inadequate." M, age 30, his wife for 11 years, denied any sexual contact with the cousin. Since they had always been honest with each other, Dr. L believed her but was still plunged into the throes of an anxiety attack so acute as to drive him to my office unscheduled — an action which would normally be unheard of for him in view of his usual correct and circumspect behavior.

Past History

Dr. L was born and raised in the Bronx, residing there until age 11, when the family moved to Westchester, NY. The father, a construction worker, covered the night shift, so the patient had sparse contact with

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him. The father he depicted as quiet, not demonstrative, but kindly, except for rare moments of tremendous rage outbursts which frightened the patient, who felt both strong love and fear of the father. He described his father as a tall, well-built, taciturn man with "a penis bigger than mine." Typical of the strong love-fear ambivalence was an incident which occurred at age 19, when the father in a rare outburst pushed the mother angrily; the patient literally threw the father out of the house; he then rushed out to bring him back, and the two — very shaken — wept in each other's arms.

Dr. L had more contact with the mother, whom he described as buxom, domineering, and over-protective. The parents fought frequently (mostly verbal battles), and the patient recalled watching them from early childhood and poignantly wishing they would stop. He was a rather isolated child as he lived in a "tough" neighborhood and was the target of neighborhood bullies.

Dr. L's education and work history were solid, and he was currently maintaining an active, well-established medical practice. His work life was very important to him, and he enjoyed a modest social life. From time to time he would lecture in his field to various professional groups.

Dr. L has a brother, five years his junior, and a son, then age 7, described as friendly and outgoing, with excellent peer relations and a good school record.

Dr. L tended to keep his feelings to himself, to brood and then "go dead inside." He frequently felt the desire to cry but could not. He did not give vent to anger as he tended to blame himself when things went awry.

In his own appraisal of himself, he saw himself as lacking flair for interpersonal relations, dull but honest and sincere, one who assumes no airs, says and does what he feels in the sense that he does not pretend to like someone he dislikes. He doubted he would be interesting even to a therapist.

Dr. L was married at age 23 and had little sexual experience prior to his marriage. His wife, 19 at the time, was also inexperienced. He noted a lack of sexual aggressiveness on his part, with intercourse taking place infrequently. He described the experience as enjoyable and culminating in a climax, but observed that his wife seemed to require an inordinate amount of foreplay. He expressed deep feelings of love for his wife. He did not recall masturbating as a child, though as an adolescent he would "sneak" it, e.g., surreptitiously masturbate while playing checkers with

an 11-year-old neighbor girl. In adulthood he was able to masturbate to climax if he felt the need. No homosexual history or fantasies were elicited.

His health history was negative except for celiac disease in infancy, ragweed allergy, and, six years ago, the finding of hypospermia. The workup on the latter came shortly after the birth of his son, when the couple tried unsuccessfully for another child, and proved to be very traumatic. At that time, bilateral testicular biopsy was performed. The patient, then an intern, felt treated cavalierly by the surgeons, who mislaid his records, took months to give him the pathology report, lost his blood test results, and were insensitive to his anxiety.

Biophysical Examination and Early Impressions

Dr. L presented as a tall, well-built, good-looking man, conservatively dressed. He was deeply agitated and seemed like a lost little boy. His voice had a monotonous, lugubrious quality, and his verbal productions were pressured and prolix. He came across as an extremely decent and likeable individual. On the couch he was very cooperative, and much more unguarded than he was in subsequent sessions. His eyes showed intense anxiety and anguish; the forehead and jaw were very tight, the throat moderately held. The thoracic segment, both ventrally and dorsally, revealed considerable spasticity; the diaphragm and pelvis seemed moderately held. Probably owing to the tremendous "crisis" state of the patient and the element of surprise of the first visit, I was able to elicit an intense vegetative breakthrough. There was also a feeling on my part of an unusually strong "tuning in" to his energy field. Thus, the head and chest were mobilized with relative ease; this was accompanied by crying and then enormous rage, after which the entire body broke into clonic contractions and the vegetative impulse went far down into the abdomen. This was followed by an expansive laughter on the part of the patient, accompanied by expressions of deep gratitude to the therapist. He looked quite radiant on departure.

The following session afforded me a view of the patient in his more usual presentation to the world. He again struck me as decent, sensitive, and conscientious, but with a somewhat plodding manner. His speech was slow and detailed. He looked handsome but lacking in phallic drive. There was something of the undertaker about him. The face looked like a tragic mask, even though the patient disclaimed any feelings of sadness

at the time. The dullness and lack of vibrancy appeared to extend to the energy field itself. I was to learn later that beneath this exterior was a man of considerable imagination, wit, and humor. I thought at the time: With some phallic push, he could be a much more exciting man.

Dr. L reported that he had felt well until five days after the session. He was then assailed again by feelings of inadequacy. I commented that his feeling of masculinity was very precarious. This rang a bell for him, and he was able to discuss his fear of impotence and fear of performing poorly as a male. This feeling of precarious masculinity has been a *leit motif* of therapy.

Initial Phase[1]

My working diagnosis was that of a chronic depressive, and I set about mobilizing the tight forehead, eyes, jaw, and chest, which elicited some genuine rage; initially the patient required my reassurance that expressing the rage was permissible; he then began, without any prompting, to take the initiative himself in showing aggressiveness on the couch.

This pattern continued for a month, following which he showed up for his session in a very passive and immobile state. It was impossible to elicit any excitation of his biosystem, which looked held in and dulled. When I described his field to him, he began to talk about his fear that therapy might unleash things best left alone. He then reported a homosexual dream and wanted to know the orgonomic position on homosexuality. After exploring this query for possible homosexual fantasies, I gave him a brief reply in terms of Reich's emphasis on genital primacy as the goal of health. His reaction was to unleash some expressions of rage against his wife, while protesting that he disliked cruelty and "hates to hurt people."

For two more sessions he was able to unload a good deal of rage, and then resistance in the form of silence and immobility appeared once more. After some probing on my part, he expressed anger at his wife's lack of receptivity to his sexual overtures. At home his anger toward her took the form of "the silent treatment" — he became taciturn and withdrawn. I pointed out he was giving me the silent treatment also, and there must be something behind it. He replied that he felt locked in a

[1] Of necessity, this narrative is greatly condensed and focusses only upon key events and the most pivotal sessions.

power struggle with me (mother transference). Following this, he was able to give vent vocally and physically to his rage against women.

I then went on vacation for a month. Upon my return, further evidence of negative transference appeared — a kind of reproach for my month-long desertion. He dreamt he goes to a doctor who is not responsive to his chest cancer. I encouraged him to air at length his negative feelings toward me: He replied that he is one patient out of many that I see for an hour, yet he thinks about me 24 hours a day. He then commiserated with me that I work so hard on him, and he doesn't let go. I suggested that this was an aspect of the power struggle he had noted before and that he had had with his mother. The sibling rivalry aspects he recognized himself. Despite this interchange, it was impossible to get a buildup of charge during the session, but at the end, during throat work, he vomited a small amount of material, which I felt was in part a conciliatory gesture of "producing" something for mama and in part hostility ("puke on you").

The following month he was still in the throes of his wife's sexual reluctance and sought out an old girlfriend with whom he had relations, something he never would have allowed himself to do before. He reported that it went well but that he missed the love feelings he experienced when embracing his wife. He did feel a certain satisfaction at his ability to reach out aggressively for sexual gratification. He felt well and expansive until the end of that month when his wife stayed out late under circumstances that made him feel almost certain she was sleeping with another man. This time, while unhappy, he did not panic or go into a tailspin. However, when it again happened the following week, he became enraged, threw his wife out of the house with verbal threats of killing her, then called her back inside (a scene reminiscent of what had transpired with his father so many years before).

Following this, he was able to show further independence in his personal life. The hay-fever season intervened; he was hard hit at first then untroubled by it. His wife had brief bouts of feeling more responsive toward him which made him feel quite well and happy. Even while reporting feeling well, his facial expression looked perpetually mournful. I began to point out his "undertaker" mien, asked where we should put the body, and tried to get him to smile. He smiled as if his face would crack. I worked vigorously on his facial mask and felt the rage rising right up through my fingers.

As the phallic push increased, a new resistance appeared in the form of

an erotic transference containing oral longings and incest strivings. On the couch he fantasized removing my blouse and exposing my breasts, and during the week had dreams of going naked into the ocean with me. I dealt only with the resistance aspect of these to which he responded with a restrained show of anger; this turned into a breakthrough of rage against me so intense that he almost fainted. The trigger was my having him sit up and strike at me directly through a specially made etherfoam pillow (designed to prevent injury to the users). This was quite a departure for a chronic depressive who defends against his phallic revenge by being gallant to women. At first he was absolutely transported with rage, then laughed with the expansiveness of it, and at the same time had the thought, "I'd like to beat the shit out of you." He departed feeling especially well and left me a thank-you note.

Castration dreams were not long in making their appearance, which I dealt with only from the ego side in terms of his marked ambivalence toward his father whom he both loved and feared. As both these emotions were constantly and consistently discharged, the patient became increasingly able to hold expansion.

He now reported experiencing a more involuntary quality of movement during intercourse. However, his precarious sense of virility was severely undermined by his wife's taking a lover, perhaps because of her own intolerance of his expansion. He had dreams that he is not the man his father is. In subsequent sessions he would rage against females, contract, and rage again. He felt hopeless and unmanly until I told him to beat the air with his pelvis; whereupon he went into a real paroxysm of rage, leaped off the couch, pulled the mattress off, attacked it, slammed it on the floor, and knocked over furniture. I pointed out that this is what lay under his Sir Galahad attitude toward women.

This intense rage against the betraying female (mother, wife) ushered in a recovery of the earliest "betrayals" — the trauma of birth and the mother's inability to gratify his oral needs. He dreamt that he was trapped in a dark tunnel and that "a version" (i.e., turning) takes place. In session, he relived his birth, experienced the trapped feeling, the "version" and a right brachial plexus pain (from being pulled by the arm). His mother later confirmed that he had been turned *in utero* and delivered by low forceps. The "evil breast," a projection of the patient's own infantile rage against the contactless mother, now appeared in the form of a transference dream: We are in session, and I thrust my breast into his mouth and manipulate it sadistically. The intense oral need for the mother and

his frustration of that need was to appear many times in therapy. I believe the chronic depressive's overriding need to be needed is a defense against this primitive unmet oral need and longing.

As his marriage continued to erode, Dr. L finally moved to his own apartment and began more serious dating. His superego immediately leaped into action: He dreamt his mother said to him, "Don't play with the Maserati" [a type of car], while his father stood by like a bull mastiff on a leash to do her bidding. Nonetheless, he entered into a very physically exciting relationship with an attractive woman, S; he also experimented with another relationship but gradually focussed on S. On the couch he felt intense excitement and his perineum itched. Midway in the year he reconciled with his wife, whom he loved (as opposed to his feelings for S which were mostly sensual) and had a "second honeymoon." Despite this he did not give up S. He became more virile and assertive, and, as the pelvis opened up, I intensified the eye work. He began to recall taking baths (at preschool age) with his mother, having love feelings for her, and visualizing her naked breasts. I had him make eye contact with me. The vegetative impulse went down to the pelvis, and he had sensuous thoughts of his wife. (He was still not into a complete reflex.)

The following week he was depressed and manifesting a strong negative transference: He said he was frightened of the feelings that were being uncovered and didn't know whether to screw me or beat me (phallic revenge against the mother). His attitude became rigid and unyielding just like his mother's, which I pointed out to him. He broke through into intense rage and then anguish *about his father*, who, in the meanwhile had developed a lymphosarcoma. As he breathed the impulse went way down to the pelvis, but stopped short of being complete.

Negative expressions toward me began to emerge more strongly: I was causing him too much anxiety — he was torn by mixed feelings of love and rage toward his father. I encouraged him to deal with the negative pole of the ambivalence first and to look mean, nasty, and sadistic. He proceeded to attack the couch with such intensity that he became nauseated (energy overload) and tasted bile; again the impulse went way down, though still not full blown.

A stage of hopelessness and masochism now set in. His libido was erratic. I gradually bantered him out of his misery, and he began to be able to laugh and joke. This was short-lived, and he again became resistive and mechanical; I released his jaw, which was very tight, and he had fantasies of sucking the breast. He experienced a sharp drop in libido for

both his wife and girlfriend. He began criticizing me, arguing with me, objecting to the tone of my voice. He declared he was a basket case and complained of anal symptoms. I gradually mobilized his rage, and he began to expand again.

By this time his field was taking on a glowing appearance, which I described to him. As he breathed through, he showed a partial reflex. He began to experience a deeper fear of his father than he had felt before. I mobilized his forehead, throat, jaw, and iliopsoas; he went out of contact, almost passing out on the couch, but came back into contact instantly when I called him; he expressed a desire to hit and kick, which he did, following which a harsh but complete orgasm reflex appeared (without clonisms).[2] He laughed with pleasure and exclaimed, "It's wonderful, it's moving by itself!" However, I knew there was still a long road to travel until his organism could sustain that much charge. We were now about five years into therapy.

The End Stage

The expansion was severely sabotaged by an overnight visit to his parents' house, which left him contracted and anxious. I went back to working on his eyes, and the reflex started up again.

The following month his father died, and the patient was able to surrender to deep crying. As he did the impulse went down to the pelvis, and the energy had a powerful, shivery quality.

He then went into deep mourning, which he tried to camouflage by becoming very busy. I read his field to him. It's as if he were saying, "Don't cross me, don't tangle with me." This led to an intense outburst of rage against the father for leaving him. He then lay on his side cuddling a towel and sobbing deeply.

Genital anxiety now appeared in the following session. He was resistive and again complained of being a basket case. I role-played his mother, which elicited an intense outbreak of rage. I pointed out how he identified with her harshness and treated himself with the same restrictive cruelty she inflicted on him. He went into another paroxysm of rage, strangling and stabbing his mother, and almost fell off the couch. The expansion was short-lived, and resistance in the form of his old characterologic rigidity (a maternal trait) made itself felt. He was very fearful

[2] Clonisms are a stage in the breakdown of armor. A full orgasm reflex is smooth and without clonisms. For some reason — unlike what occurs in most patients — clonisms rarely appeared in this patient except in the initial stages of therapy.

even to move on the couch, and I told him about the "descent into hell" that may precede the final letting go. With this interpretation of genital anxiety he started giving in, then stiffened again, became paranoid and accused me of distorting an insurance letter I wrote for him so he wouldn't know how sick he was. I had him attack me verbally, which released the spasm and left him feeling very well.

The virility issue which had originally brought him to therapy and which had appeared in his relationship with his wife, now came through strongly again. He complained of loss of libido and in the course of breathing recalled an incident at age 9 of nudity with his father, who commented to him, "You've got nothing to show." He became enraged on the couch and shouted, "I'm a man, too!"

Following this, the oral deprivation and rage again surfaced — he fantasized attacking his girlfriend's breast, biting it and punching it. He felt the oral longing and became depressed, then enraged. His libido for both wife and girlfriend returned, and he was able to enjoy both women, maintaining the split between tender and sensuous feelings which this situation epitomized.

In therapy, I continued "educating" him to his energy field which now often took on a blowing quality, indicating capacity for very high charge. The crystallizing out of the oedipal transference proceeded apace: He had fantasies of raping me, which he enacted with a pillow. In life he was much more spontaneous. He then developed a mild bulimia in the form of sporadic eating binges. On the couch he recalled that he had been a chubby child and that his father had made him feel "unmanly, like a fat ball of shit." With that he leaped from the couch, pulled the mattress off, slammed it against the floor, and threw things across the room. This passion matched his sexual passion at home which he depicted as occasioning "intense climaxes."

In session I still pursued his style of blocking his energy field — invoked whenever he felt contracted — exactly like his mother blocked it: I imitated his mother, called him by his mother's name, and set off another paroxysm of rage against women. He began to fear doing something wrong (damaging the female whom he needs orally). Over and over again we worked on how thoroughly brainwashed and conditioned he was energetically, like Pavlov's dogs, and that the mother could pull the switch on his expansion instantaneously. Gradually he became more and more adept at handling his mother and resisting her directives to contract.

At this point, a pivotal event took place which subtly changed his self-

image. Since his testicular biopsy of a decade before, he was still uncertain as to the cause of his hypospermia. I had hoped to get him to the point where he would face the issue and put it to rest. He now felt impelled to pursue it, and a diagnosis of a surgically correctible varicocele was made. This placed the hypospermia on a purely mechanical basis after, as he put it, "ten years of feeling unvirile." He had unconsciously linked the purely physical fact of hypospermia with his precariously held masculinity, an issue so threatening that he could not even reality-test the physical findings for a decade. Behaviorally, he felt a lot freer after bringing it all out in the open. He said he was even able to joke with certain formidable patients of his whom he used to dread seeing.

Though heartened by these developments, I wondered how long he could hold this expansion. He reported having intensely pleasurable sex with both his women (still splitting his genital impulses), feeling very alive, and overeating. For the latter, he decided to go on a fasting and purging routine, which was unconsciously aimed at bringing down his energy. I worked again on his energetic identification with his plaguey mother (the chief line of defense) and how he attacked his own field expansion. He began attacking me verbally, called me a big brain hysteric, and then switched the rage to his father (father transference). Castration dreams followed, and, in session, he had recall of his father's hands raising welts on his buttocks and his father's support of his mother's tyranny. This led to a strong release of rage.

Toward the year's end we took stock of where he was in therapy: He reported he was able to deal better with people, was moving easily in every area of his life, and felt much more in contact. Meanwhile the quality of the reflex was becoming smoother.

Though he was far more spontaneous and alive than ever before, his field still felt a little "cautious" to me. We continued to clean up residuals of the parental transference and issues about his virility. He still did nothing about the varicocele, which would have been a simple procedure. His sex life he reported as excellent, and he had almost broken off completely with his girlfriend, concentrating his libido mainly on his wife. We explored the significance of fixing the varicocele — he was somehow afraid that laying claim to his full masculine trappings would necessitate his living up to them. He was then able to undergo the procedure successfully and felt very well after it.

The following year, the immediate postoperative period, saw a great increase in sexual excitement in both himself and his wife, and we decided mutually to reduce the number of therapy sessions. He organized

his staff along lines of a work democracy with an enormous increase in *esprit de corps*. He felt positive and happy in his life, took a leadership role in community projects, felt comfortable at board meetings, "laid back" and playful — quite a contrast to the "lugubrious undertaker" mien of former years. On the couch, breathing continued to elicit a complete reflex.

Amidst this optimistic picture he went into a sudden tailspin, seemingly without cause in a very positive life. A chance remark revealed the difficulty. His son was growing into manhood, as evidenced by his getting ready to leave home for college. This set off a whole train of feelings about his dead father, the passing of an era, his own role as a father, etc. When I pointed this out, he relaxed, expanded, and breathed through into a sustained reflex. Subsequently we reduced the visits to about 10 times a year.

In anticipation of this case study, I asked him for a subjective impression of his genitality: He reported a change in his sexual functioning in terms of a much more "involuntary quality," his passing out momentarily at acme, and his feeling "intense happiness and love with my wife; whereas, before I used her as a sex object." He also noted that he is deriving great satisfaction from his work, his community activities, and his personal relationships. He has a positive self-image, feels in good contact, and is much more spontaneous and resilient.

His feelings about his virility were recently put to a severe test. His wife unexpectedly became pregnant, occasioning much soul-searching as to the merits of having a mid-life child and the subsequent decision to let the pregnancy continue. His wife then miscarried, and a blighted, unfertilized ovum was found, indicating a possible reproductive defect on the father's part. I was concerned about the emotional effect of this finding, but, in session, it was clear that the patient suffered no threat at all to his masculine image and, after a little eye and chest work, experienced an intense reflex surrender to the energy. He laughed delightedly and exclaimed at his sense of freedom, saying that he felt "no restrictions anywhere." He thanked me warmly, and we both basked in the glow of a strong and expanded energy field.

Discussion

The patient was seen once weekly for 10 years and then about 10 times a year for the past three years. The full orgasm reflex first appeared in harsh form about five years after the beginning of therapy but did not

really become well entrenched until after another four years. The reason for this lies in the dynamics of the chronic depressive (genital revenge blocked by oral inhibition), i.e., his special susceptibility to contraction and his difficulty in maintaining aggression. Throughout the course of treatment, there was a constant alternation of expansion and contraction, and while this is the usual pattern for patients in therapy, the chronic depressives seem to alternate at much shorter intervals and sometimes within the course of a single session. This is not to be confused with the cyclic mood swings of the manic-depressive, but is due to the patient's precarious hold on the phallic position as a defense against anal submission (hence, for example, the homosexual fears even in phallics who are not homosexual). This susceptibility to contraction also derives from the patient's stance in life — that of being caught between a punitive (maternal) superego and a demanding (paternal) ego ideal, making for enormous and paralyzing guilt.

Another factor in this patient's history also contributed to his contraction-proneness and was the reason I had him return for sporadic followups once the major work was done: The superego in this patient, derived from incorporating the mother's inhibitions, had a frank masochistic component, in that the mother was extremely intolerant of any movement of energy, which she instantaneously scotched. This extended to her entire environment to such an extent that if a social gathering in which she partook threatened to be pleasant, she would immediately find some way to throw cold water on it by invoking the most nit-picking, negative trivia to carp about. Thus, the patient was unusually well-conditioned to scotching any expansive energy movement in himself. I quickly came to the conclusion that, to counteract his strong energetic programming, I would have to educate him to what his energy field was doing by repeatedly describing it to him, thereby expanding his awareness of what was happening to him biophysically. Chronic depressives, in my experience, do not do well with pushing and prodding (this patient's mother was a bulldozer), but they are extremely sensitive to what happens to them energetically, once it is within their awareness. Consistent somatic work on tight segments especially ocular, oral, and thoracic with much gagging, biting, and vomiting was frequent and necessary, but the most significant movements of energy came from transference interpretation, dream analysis, character work, and proprioceptively tuning him into his energy field.

The most challenging aspect in treating this character type is the mo-

bilization of rage since their gallantry, guilt, and adeptness at self-deprecation make a powerful defense. What is striking in this history is the intensity of rage discharged over and over again — in a seemingly endless succession of paroxysms. This is only possible when the energy field is truly excited. Of interest is the first appearance of the full, though initially harsh, reflex, which manifested only after dealing extensively with castration anxiety (the feared punishment for the genital incest strivings and the deepest meaning of the virility issue manifested on the ego side). This became possible after consistent, *ad infinitum* analysis of the patient's chief resistance — his identification with the castrating mother, which constituted his principle style of armor, expressed in his mien, facial expression, the way he moved and talked, etc. (The armor is, of course, the superego in psychoanalytic terms.) Subsequently, a long period of restructuralization was necessary, getting the patient to tolerate and sustain expansion and clearing up the residual blocks which invariably show up once the pelvis is reached.

This case illustrates the possibility of attaining genitality even within the setting of a scarred and armored society. It fulfills the criteria of progression of events described by Reich, including the breakdown of the patient's existing sexual functioning, the severe contraction and despair accompanying the final stages of genital anxiety; the continual alternation of resistance and breakthrough which marked the entire course of therapy; and the need for transferentially working through the genital incest strivings, the castration anxiety, and the early pregenital (oral) deprivation, which placed such a distinctive stamp on the patient's character structure. It also meets the criteria for the attainment of genital primacy: the capacity for complete involuntary orgastic discharge as a regulator of the energy economy; marked bodily and behavioral changes; improved quality of life; and interest in supporting a high quality of life for others (e.g., his spontaneous reorganization of his office along work democratic lines). As such, it provides eloquent and compelling testimony that genitality is an attainable objective and must be the ultimate goal and guiding principle of every deep-reaching therapy.